DISCUSSION PAPER

MANDATORY CONTINUING EDUCATION

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EXECUTIVE SUMMARY

This Discussion Paper was written to raise questions and to discuss the various aspects of the mandatory continuing education (MCE) issue.

The public is concerned about professional competence, because of the risk involved in seeking services from an incompetent professional, and the feeling that the quality of services is not consistent with their price. Professionals and professional associations are concerned that incompetent members are giving a bad name for all. Employers are in a unique circumstance - they can set MCE requirements as a condition of employment. Insurance companies are concerned about malpractice suits.

Professional obsolescence is a related concern which arises due to the development of new knowledge, technologies, and processes. Professionals can rapidly become less competent than they were upon graduation from their initial training.

Maintaining or improving competency through continuing education (CE) as a part of the career of any professional is undisputed. However, what is disputed is whether participation in CE should be mandatory for the renewal of registration or license, or whether it should be left voluntary.

The several studies that have been done on the effectiveness of CE or MCE provide unsatisfactory results or have various methodological problems. There is no conclusive research evidence that continuing education (voluntary or mandatory) does, or does not, improve a professional's skills.

MCE began in the U.S. with Kansas, in 1968, becoming the first state to pass legislation. As of 1990 there were 393 pieces of MCE legislation (among 16 selected professions) in the 50 states and the District of Columbia. Iowa had MCE requirements for all of its professionals. Certified public accountants must meet such requirements in 48 of the states while optometrists must do so in 47.

The growth in MCE legislation did slow down in the early 1980s causing the opponents of MCE to claim that the movement toward MCE was in the process of reversing. The slowdown in the early '80s has been attributed to the large number of states that had such requirements, the sunset clauses in existing MCE legislation, and scepticism over the wisdom of such requirements. However, after repealing their MCE legislation, some states then reenacted it. The current evidence indicates that MCE requirements in the U.S. are increasing.

The growth of MCE in Canada followed a different time frame than in the United States. In 1986, a survey of selected occupations indicated there were only seven pieces of MCE legislation for all professions in all provinces and territories. By 1991 the number had increased to 40 with British Columbia, Alberta and Saskatchewan each having seven professions with MCE requirements. Optometrists, certified general accountants and pharmacists have MCE requirements in eight, six and five provinces or territories respectively. While lawyers and doctors have MCE requirements in 33 and 21 states respectively, no such requirement exists in any province or territory.

In Alberta, seven professions - chiropractors, pharmacists, dentists, dental assistants, optometrists, emergency medical technicians and certified general accountants - have MCE requirements. Fourteen other professions have enabling provisions in their legislation whereby regulations regarding MCE could be passed. Furthermore, eight groups regulated under the Health Disciplines Act could have a MCE requirement because the Health Disciplines Act has a provision for regulations on continuing education as a condition of renewing registration.

If and when the constitutionality of MCE is challenged in Canada, it will likely be under the Canadian Charter of Rights. MCE has been challenged several times in the U.S., beginning in 1889. The court decisions indicated support for reasonable MCE requirements.

The main focus of the Discussion Paper is the arguments for and against MCE. The arguments supporting MCE are:

1) prevents professional obsolescence
2) voluntary participation in CE is inadequate
3) MCE will not deter dedicated professionals from exceeding legal requirements
4) enough high quality programs will be available
5) cost to the professional and to the consumer may not be that substantial
6) MCE could increase public confidence in professionals
7) difficulties in implementation, while real, can be overcome
8) the existence of strong support for MCE.

The arguments against MCE are:

1) learning cannot be forced
2) application of knowledge cannot be forced
3) voluntary participants resent MCE
4) required courses are not always relevant to the professional's job
5) completion of MCE requirements does not guarantee competence
6) the cost to the professional
7) the cost to the consumer
8) administration problems for the professional associations

9) negative implications for employers of professionals
10) problems with reciprocity of CE credits between provinces
11) quality of programs may decrease
12) the existence of strong opposition to MCE.

When deciding how MCE should be implemented, it has to be determined who should have control and responsibility over the MCE program. If it is to be government, then MCE should be implemented by statute or regulation; if the professional association is to have control, then the statute should contain enabling provisions.

A major argument against government involvement in a MCE scheme is that this would be an infringement on professional autonomy. The proponents of government involvement feel that the professionals already have enough control, and now the public should have more say over the quality of services that are offered. It must be recognized that the government is at least required to provide the enabling legislation for MCE, but beyond that, there is no agreement on what specific role, if any, it should have in the MCE scheme.

The possible penalties for not meeting the MCE standards could be:
1) a fine;
2) probationary registration or certification;
3) registration or certification limited to certain functions;
4) denial of renewal of registration or decertification.

With respect to the cost of a MCE program, the public, the professionals, employers, professional associations, and the provincial government are all candidates to incur this expense. However, in the final analysis, the consumer will be paying much of the costs for the MCE scheme.

Those who support MCE, and feel it is needed in present day society should advocate carefully designed MCE schemes to keep potential negative effects to a minimum. For those strongly opposed, but who still feel professional incompetence is a problem, an alternative will have to be sought. Among the alternatives are encouragement by professional associations and employers for individuals to engage in continuing education, practice reviews of professionals by the professional association, evaluation of professionals by their employers, a requirement for individuals to pass an examination prior to being re-registered and a requirement for individuals to provide proof that they have a given number of hours of practice since last being registered.

Individual professionals, professional associations, employers of professionals and governments are all faced with a demanding and complex task as they attempt to balance the rights and responsibilities of professionals with the rights and responsibilities of the public.

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INTRODUCTION

Education for professionals has been a topic of discussion for a long time. This discussion or debate began with what had to be learned in order to graduate from a particular learning institute and begin practise. Later it became accepted that it was part of a professional's responsibility to engage in lifelong learning. Over the last twenty years the debate has evolved about mandatory continuing education (MCE). This debate arose from concerns that professionals were not accepting the responsibility of maintaining competency. Thus, it was felt that MCE should be legally required for license renewal, and at the same time it would act as a mechanism to weed out incompetent professionals.

The arguments for and against MCE have resulted in a complex issue. Any study of it requires that these arguments be examined. As well, a more in-depth look should be taken of the general background to this issue. Other elements, such as the purpose and effectiveness of past schemes, can be studied. It is useful to review the existence of MCE in the United States and Canada. The constitutionality of MCE is an issue. How can MCE be legislated? Who should pay for it? What should government involvement be? What penalties should be imposed on those not meeting the MCE standards? These are questions that must be addressed.

This Discussion Paper deals with each of the above issues, using as a data base the research that has been carried out to date in Canada and the United States, an analysis of documentation from other provinces, and an analysis of Alberta legislation.

I. General Background

A. Particular Concerns Over Professional Competence

A concern to the consumer is the risk involved with seeking services from an incompetent professional. The risk may involve both physical and financial harm.

However, it is not just the consumer who is concerned with professional competence. Professionals want to be protected from the other members who, due to their incompetence, are giving a bad name for all. As well, professional associations are interested in maintaining professional credibility. Employers and insurance companies have their own particular concerns. Employers do not want to provide poor service nor to pay for incompetent employees. Insurance companies are concerned about paying out large sums of money in lost malpractice suits.

B. Professional Obsolescence

> Few will argue the validity of the concept that the health professional, once licensed, remains competent the rest of his or her life. Such a concept is no longer acceptable to either consumers or the professionals themselves. (Cooper, 1981, p.70)

The initial certification of professional competence at the completion of formal training no longer ensures that the practitioner will be aware of recent advances in the field, or will use them in a career that may span 40 years or more. (Robinowitz, 1980).

As a result of the development of new technologies, techniques, and equipment, the changing health care needs of society, increasing specialization, changes in work settings, and the increasing sophistication and complexity of client systems, professional

obsolescence can easily set in. (Pennington, 1980) For instance, it has been estimated that medical information doubles every eight years, and a doctor's competence has a half-life of five years. Half-life has been defined as the time after completion of professional training when, because of new developments, professionals have become roughly half as competent as they were upon graduation. (Loveland, 1984)

C. Continuing Education

These concerns over professional competence and the difficulty professionals experience in keeping up to date have resulted in the formation of a consensus that continuing education should be part of the career of any professional. Continuing education in health care has been defined as:

> Educational opportunities beyond formal education and initial entry into a profession to enable practitioners to maintain competence, to become aware of new developments and to provide responsible quality health care services. (Loveland, 1984, p.52)

The same definition applies to other professions. Continuing education should improve the services given to the public, and protect the public against unqualified or unsafe practitioners.

Participating in continuing education has usually been on a voluntary basis. However, it can and has been used as a "penalty" in the discipline process. Continuing education can also be imposed on a professional indirectly by the threat that repeated examples of incompetent performance will lead to expulsion from the profession. (Swan, 1979) Continuing education is required for salary increases and promotions for some professions in some jurisdictions.

For the purposes of this paper, continuing education will be discussed as a mandatory or voluntary requirement for renewal of registration or licensure.

D. Views on MCE

The view of the parties that would be affected by MCE are naturally quite varied.

> Professionals have suggested that, in some cases, MCE protects them from the damage of their less competent colleagues who are forced to keep up with recent developments in their field whether they like it or not. (Bennof, 1984, p.1)

However, other professionals feel that MCE is an infringement on professional practice, and that their professional organizations have acted against their interests in supporting legislation for MCE.

> As for professional associations, they feel "torn when it comes to a stand on increased education, facing a loss of professional membership on the one hand and a loss of professional credibility on the other." (Killian, 1980, p. 221)

Some members of the general public feel it is a professional obligation to keep current in one's profession. (Tillis, 1979) Because there are those professionals that neglect this facet of their professional obligation, "Some consumers of professional services view MCE as a mechanism through which the public can exercise a degree of control over the product of its specialists who otherwise answer only to themselves." (Bennof, 1981, p.1)

Other members of the general public disagree:

> The opponents of MCE do not, of course, question the value of CE; they question whether it should be required. Does required course work weed out the incompetent and help people keep up with their field? (Lisman, 1980, p.126)

The following assumption regarding the effects of MCE is often made:

> If exposed to meetings, courses, or other educational activities, the professional's existing knowledge and skills will be reinforced while new knowledge and skills

> are acquired which, in turn, will lead to quality patient care. (Dowling, 1985, p.1)

The accuracy of such an assumption, as well as the other views expressed above, will be expanded further later in this paper.

II. Purpose and Effectiveness of MCE

A. Purpose of MCE

MCE evolved as an approach which would achieve increased competence.

B. Studies of the Effectiveness of MCE

Studies of the effectiveness of MCE have been impacted by studies of CE. While there is a strong belief among professionals and the public that CE will improve both knowledge and practice, there is no conclusive evidence that CE does, or does not, improve a professional's skills.
As McCarberg (1981) stated:

> A review of the available literature on the efficacy of CE leaves one with an unmistakable sense of uncertainty. The cogent study with irrefutable and generalizable results has not been conducted, and the wide-scattered data available from various research projects lead mostly to confusion, not clarity. (McCarberg, 1981, p.90)

Despite the lack of research evidence, continuing education is supported by virtually every professional association and there is a high level of participation in CE by professionals on a voluntary basis. This situation reflects the world of business and industry which are increasingly dependent on CE and training to remain profitable.

Studies of the effectiveness of MCE in the late '70s were inconclusive. Dowling (1985) found no practical significant

differences between study populations who were under mandatory or voluntary continuing education systems. Lloyd and Abrahamson (1979) who reviewed studies of the relationship between continuing medical education and physicians' performance concluded that the probability of continuing medical education being successful is approximately .50.

Some later studies do show a positive impact of MCE. Richards and Cohn (1983) reached this conclusion in summarizing 36 studies that assessed changes in the performance of physicians or patient outcomes. Morris (1983) reported similar findings following a major study financed by the National Science Foundation of 400 engineers.

While Phillips (1987) indicated that there is increasing evidence that continuing education affects performance, the research evidence on CE or MCE to date is inconclusive - not an unusual result in the social science field when changes in behaviour are difficult to measure and when uncontrolled intervening variables are always present.

III. MCE in the United States

Any discussion of MCE should include a review of this practice in the United States. It was there that this issue evolved.

A. History of MCE

In 1967, growing pressure from the public sector prompted a U.S. commission, the National Advisory Commission on Health Manpower, to recommend that professional associations and governmental regulatory agencies take steps to assist practitioners in maintaining competence. Shortly after this, Kansas became the first state to require continuing education for membership. Then in 1968, the Oregon Medical Association became the first state

society to require continuing education for membership. (Loveland, 1984). If the requirements were not met, then the physician was expelled and would lose various benefits, but not the right to practise.

The movement toward MCE picked up pace in 1971 with the Department of Health, Education, and Welfare's (DHEW), "Report on Licensure and Related Health Personnel Credentialling". The report contained the following statement:

> The professional organizations and states are urged to incorporate a specific requirement for the assurance of a continued level of practitioners' competence as one condition in the re-credentialling process. (Edwards and Green, 1983, p.45)

"This statement was widely interpreted to mean that DHEW endorsed MCE education requirements for re-licensure or re-certification." (Edwards and Green, 1983, p.45) This was not the intention of DHEW in making the statement and it tried to say so in further public statements made in 1973 and 1977. However, these were either misinterpreted again, or were just ignored. More states enacted MCE legislation.

In 1971, New Mexico passed legislation requiring physicians to engage in continuing medical education. They had to complete 120 credit hours of continuing medical education every 3 years in order to renew their license to practise. By 1978, 20 other states had followed New Mexico's lead.

In 1977, Iowa's state legislature passed Senate Bill 312 mandating continuing education for all professions (a total of 23) licensed in that state including engineers, land surveyors, barbers, and cosmetologists. (Stein, 1981, p.104) This legislation in Iowa resulted in architects and engineers having continuing education mandated for the first time.

By the end of the 1970s, every state had jumped on the MCE education 'bandwagon' and had legislation mandating CE for some of its professionals. The most heavily regulated states were Iowa then New Mexico, Kansas, California, and Kentucky. The least regulated were South Carolina, Rhode Island, Missouri, Virginia, and Mississippi. Also, at this time, the most heavily regulated profession was optometry, followed by nursing home administrators, podiatrists, certified public accountants and physicians, while the least regulated professions were engineers, architects, physical therapists, and dentists.

B. Current Situation of MCE in the United States

The following information regarding the current situation of MCE in the U.S. was obtained from Louis Phillips, formerly Associate Director of Managerial Services for the Georgia Center for Continuing Education at the University of Georgia and currently a continuing education and training consultant.

As can be seen in the following tables, all 50 states and the District of Columbia have a MCE requirement in at least one of the sixteen professions listed. Given the above information regarding MCE in the states in the late 1970s, it is interesting to examine the 1989 data in the charts. The most heavily regulated state is still Iowa. New York is the least regulated state. The most heavily regulated professions now are optometry, certified public accountants and nursing home administrators. The least regulated are architects and engineers.

Tables 2 and 3, showing the trends in MCE for the different professions, indicates that overall MCE is continuing to increase. This is interesting because in the early 1980s there were claims that the amount of MCE legislation was going to decrease. Lawyers, psychologists, pharmacists, physical therapists and social workers have become substantially more regulated in the last three years.

The only state in which there was less MCE legislation in 1989 than in 1986 was Utah. Mandatory CE requirements in this state were removed for physicians, real estate personnel and social workers as was a special circumstance requirement for licensed practical/vocational nurses. However, in the same period, MCE requirements were instituted for lawyers and nursing home administrators.

TABLE 1

STATUS OF MANDATORY CONTINUING EDUCATION FOR SELECTED PROFESSIONS - 1989

	Architects	CPA's	Dentists	Engr (Prof)	Lawyers	Nurses	Nur Hm Adm	Optometry	Psychology	Pharmacy	Phy Therapy	Physicians	Real Estate	Social Work	LPN's	Vet Medicine
Alabama		X			X	E	X	X		X	E		X	X		X
Alaska		X				S		X	X	X	X		X			X
Arizona	E	X					X	X		X		X	X			X
Arkansas		X			X		X	X	E	X		E	X	X		X
California		X	X			X	X	X		X		X	X		X	
Colorado		X			X	X									X	X
Connecticut		X						X		X			X			
Delaware		X			X		X	X	X	X	X	X	X	X	X	
D.C.		X					X	E		E	X	E	X	E	X	
Florida	E	X	X		X	X	X	X	X	X		X	X	X	X	X
Georgia		X			X		X	X	X	X	X		X	X		X
Hawaii		X						X				X	E	-		
Idaho		X			X		X	X	X	X			E			
Illinois		X					X	X		X		X		X		X
Indiana		X			X		X	X		X				-		E
Iowa	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Kansas		X	X		X	X	X	X	X	X	X	X	X	X	X	X
Kentucky		X	X		X	X	X	X		X		E		E	X	X
Louisiana		X			X		X	X	E	X		S	X			
Maine		X					X	X	X	X		X	X			
Maryland		X					X	X	X	X		X	X		X	
Massachusetts		X	X			X	X	X	X	X		X		X		
Michigan		X				E	X	X	E	X		X	X			
Minnesota	E	X	X	E	X	X	X	X	E	X	E	X	X			
Mississippi		X			X	S	X	X		X			X		X	
Missouri		X			X		X	X		X		X	X			
Montana		X			X		X	X		X	E		X		X	
Nebraska		X	X			X	X	X		X		E	X	X	X	
Nevada		X	X		X	X	X	X	X	X	X	X	X	X	X	
New Hampshire	E	X	E			S	X	X	X	X	S	X	X		X	
New Jersey	E	X					X	X		X			-			
New Mexico	E	X	X		X	X	X	X	X	X	X	X	X	X	X	
New York		X					X									
North Carolina		X			X		X	X	E	X			X			
North Dakota		X	X		X		X	X		X	X		X			
Ohio		X	X		X	E	X	X		X		X	X			
Oklahoma		X	X		X		X	X	E	X			X			
Oregon		X			X	S	X	X	X	X			X			
Pennsylvania		X					X	X		X		S				
Rhode Island		X						X	X	X		X	X			
South Carolina		X			X		X	X		X						
South Dakota		X	X				X	X		X			X			
Tennessee		X			X		X	X		X			S			
Texas		X			X		X	X	E	E	X		S	X		
Utah		X			X		X	X	X							
Vermont		X			X			X	X	E			X			
Virginia					X		X	X					E	X		
Washington		X			X	S	X	X	X	X		X	X	E		X
West Virginia			E		X		X	X	X	X				X		
Wisconsin					X		X					X		-		
Wyoming		X			X	S	X	X	E				X	X		

(X) required (E) enabling legislation
(s) under certain circumstances (-) not licensed
Corrections and updates are invited

TABLE 2
GROWTH OF MANDATORY CONTINUING EDUCATION FOR SELECTED PROFESSIONS
1977 TO 1989

	1977	1979	1980	1981	1982	1984	1986	1989
ARCHITECTS	0	1/1	1/1	1/2	1/6	1/6	1/6	1/6
CPAs	23	28	36/1	38/1	37/1	43/1	47	48
DENTISTS	8	9/1	9/1/1	11/1/1	10/0/1	10/0/1	13	14/2
ENGINEERS (PROF.)	0	1	1/2	1/2	2/2	2/2	2/2	1/1
LAWYERS	7	8/8	9/8	9/0/9	10/0/8	12/0/8	20/0/4	33/0/4
NURSES	6/3	10	11/2/7	10/4/4	11/4/4	11/2/5	11/2/7	11/3/6
NURSING HOME ADMIN.	37	42	43	44	42/1	44/1	43	46
OPTOMETRISTS	45	45	44	46	46	46	46	47/1
PSYCHOLOGISTS		7/6	8/6	12/9	11/9	12/9	13/8	19/8
PHARMACISTS	14	21	21	22	24/4	30/3	36/3	42/3
PHYSICAL THERAPISTS		3	3	3	3	3/1	4/2/1	10/3/1
PHYSICIANS	17/11	20/4	20/4/1	20/4/1	20/4/1	18/4/1	21/3/2	22/4/2
REAL ESTATE SALES AND BROKERS	11	11	14/1	17/1	21	22/0/3	29/0/3	33/3/2
SOCIAL WORKERS	6	10	10	11	15	18	20/2/1	26/4/3
LPNs		8/3	11/1	10	12	10/1/1	10/1/7	12/0/0
VETERINARIANS	18	19	22	23/2	22/1	24/1	26/1	28/1
TOTAL PIECES OF MCE LEGISLATION	192	243	263	278	287	306	342	393

NOTE: The first digit represents number of states with mandatory requirements.
The second digit represents number of states with enabling legislation passed.
The third digit represents number of states with requirements under certain circumstances.

Revised 1989

TABLE 3

STATUS OF MANDATORY CONTINUING EDUCATION FOR SELECTED PROFESSIONS FOR 1986 AND 1990

Number of States[1]

	Required by statute or regulation		Enabling legislation passed		Required under certain circumstances	
	1986	1990	1986	1990	1986	1990
ARCHITECTS	1	1	6	6		
CERTIFIED PUBLIC ACCOUNTANTS	47	48				
DENTISTS	13	14	0	2		
ENGINEERS (PROFESSIONAL)	2	1	2	1		
LAWYERS	20	33			4	0
NURSES	11	11	2	3	7	6
NURSING HOME ADMINISTRATORS	43	46				
OPTOMETRISTS	46	47	0	1		
PSYCHOLOGISTS	13	19	8	8		
PHARMACISTS	36	42	3	3		
PHYSICAL THERAPISTS	4	10	2	3	1	1
PHYSICIANS	21	22	3	4	2	2
REAL ESTATE SALESMEN AND/OR BROKERS	29	33	0	3	3	2
SOCIAL WORKERS	20	26	2	4	1	3
LICENSED PRACTICAL/VOCATIONAL NURSES	10	12	1	0	7	0
VETERINARIANS	26	28	1	1		

Note: Information obtained from national professional associations.

[1]Includes District of Columbia

IV. Mandatory Continuing Education in Canada

Table 4, page 14, outlines the incidence of MCE for selected professions in Canada. In British Columbia, Alberta and Saskatchewan, seven professions in each province have such requirements. Manitoba has six professions having MCE. Prince Edward Island and Nova Scotia have five each. At the other end of the spectrum, no professions have a MCE requirement in Quebec, Newfoundland and the Yukon Territory. Optometrists have MCE requirements in eight provinces, certified general accountants in six provinces and one territory, and pharmacists in five provinces. On the other hand, architects, engineers, doctors and lawyers do not have MCE in any province or territory.

It is of interest to note the very slow incidence of MCE requirements in Canada until the mid '80s and the substantial increase since then. While a survey of provinces and territories in 1986 may have been incomplete because some MCE requirements are in by-laws pursuant to private acts and are not published, it indicated the total number of MCE requirements for all provinces and territories for all professions was seven. A similar survey in late 1990 and early 1991 indicated the number had risen to 40.

In some respects the Canadian scene reflects the American situation. In both countries optometrists, accountants and pharmacists are among the professions with the most MCE requirements. Architects and engineers have no MCE requirements in any province or territory and such requirements exist in only one state. On the other hand, lawyers and doctors have MCE requirements in 33 and 22 states respectively but no province or territory has such requirements. While there are no MCE requirements for doctors in any province, the College of Family Physicians of Canada, a voluntary association, requires members to engage in 50 hours per year of educational activity as a condition for renewing membership. The requirement, run on an honour basis,

may include up to 25 hours of self-study but the balance must be approved programs. A sister organization in the United States has a similar program.

A recent development in Ontario is worthy of note. Following a six year study, a 1989 report commissioned by the Minister of Health entitled, "Striking a New Balance: a Blueprint For The Regulation of Ontario's Health Professions" recommended that the governing body of each profession be required through regulation to establish a program to maintain and enhance the ongoing competence of members. Legislation to effect this recommendation was tabled in the Ontario legislature in June 1990 but, due to the defeat of the government and the subsequent election, died on the order paper. Ontario officials indicate the legislation will be re-introduced in the spring of 1991. Details of the relevant sections of the legislation are included in Appendix I.

TABLE 4

MANDATORY CONTINUING EDUCATION IN CANADA

	British Columbia	Alberta	Sask.	Manitoba	Ontario	New Brunswick	Nova Scotia	Prince Edward Island
Chartered Accountants	X		X	X				
Certified General Accountants	X	X	X	X		X	X	
Chiropractors	X	X					X	
Dentists	X	X	X	X				
Dental Assistants		X	X					
Denturists	X							
Dental Hygienists			X					
Dental Technicians	X							
Dieticians							X	
Nurses				X				
Pharmacists		X	X	X			X	X
Physiotherapists								X
Psychologists								X
Optometrists	X	X	X	X	X	X	X	X
Emergency Medical Technicians		X						
Social Workers								X

An X indicates the profession noted has a MCE requirement in the province noted.

* Quebec, Newfoundland and the Yukon Territory have no MCE requirements for any profession. Only Certified General Accountants have such a requirement in the Northwest Territories. In Quebec all professional legislation comes under a Professional Code.

* The information in the chart was supplied by contacts in each province or territory and through discussions with national and provincial professional associations' staff in the fall of 1990 and January 1991.

V. MCE in Alberta

As noted in Table 4, page 14, seven Alberta professions have regulations which require MCE for renewal of registration or license. The first MCE legislation was for pharmacists. A 1976 regulation (amended in 1979 and 1980) states that pharmacists must acquire a minimum of 45 units of continuing education every three years, but not more than 30 of those can be acquired in one given year. A 1984 regulation required dentists to accumulate 200 credit hours of continuing education every five years in order to maintain certification as a registered practitioner. A 1987 amendment to this regulation reduced the requirement to 150 hours. A regulation pursuant to the Optometry Act in 1985 requires members of the optometry profession to acquire 60 hours of continuing education in a three year period. Emergency medical technicians must meet the MCE requirement of 120 educational credits every two years as set out in a 1985 regulation passed pursuant to the Health Disciplines Act. By-laws have been enacted providing MCE requirements for certified general accountants, chiropractors and dental assistants.

Legislation for the following professions has a provision which would enable MCE regulations to be passed:

Architects
Certified General Accountants
Certified Management Accountants
Chartered Accountants
Chiropractors
Dental Assistants
Dental Hygienists
Dental Technicians
Dietitians
Engineers
Land Surveyors
Foresters
Nurses
Occupational Therapists
Psychologists
Physical Therapists
Veterinarians

Furthermore, the Health Disciplines Act has enabling provisions

which would make it possible for the following to institute MCE requirements:

Acupuncturists
Combined Laboratory and X-ray Technicians
Hearing Aid Practitioners
Licensed Practical Nurses (Nursing Assistants)
Mental Deficiency Nurses
Medical Radiation Technologists
Psychiatric Nurses
Respiratory Technologists

In addition, the Professional & Occupational Associations Registration Act has provisions for regulations on MCE. Groups regulated under this act include:

Certified Management Consultants
Community Planners
Home Economists
Local Government Managers
Professional Biologists
Purchasing Managers

The Dental Disciplines Act which was proclaimed in November 1990 has a MCE enabling provision. Dental assistants, who are now regulated under this Act, currently have by-laws on MCE. This group has declared their intention to implement MCE requirements through regulation in the very near future. Dental hygienists may also include MCE in their regulations.

Two other developments in Alberta deserve comment: chiropractors who currently have a by-law outlining MCE requirements are requesting these provisions in regulation pursuant to an enabling provision in the Chiropractic Profession Act. The Legal Profession

Act, passed in 1990 but not yet proclaimed, has no enabling provision for regulations regarding MCE.

VI. Constitutionality of MCE in Canada and the United States

A. MCE as a Possible Charter Challenge

Any legislation or proposed legislation that compels or prevents a person from doing something has the potential to violate the Canadian Charter of Rights and Freedoms.

Currently, no aspect of MCE has been challenged in the courts so there are no Canadian precedents for courts to rely on when and if MCE is challenged.

B. U.S. Decisions

A sample of U.S. court cases are included in Appendix II. The decisions in these cases support the following principles:

- a MCE requirement does not deny "due process of the law"
- requiring additional provisions beyond initial certification requirements is acceptable if the general welfare of the public is to be protected
- states do not have an unqualified right to impose MCE requirements

It must be noted that the issue of MCE has not been decided upon by the U.S. Supreme Court.

The attitude of the courts in the United States appears to be that

> no person has an absolute right to practice a profession. The practitioner only has a conditional right that is subordinate to the police power of the state to protect and preserve the public health. (Fink, 1981, P.1770)

Whether such an attitude will prevail in Canada, if and when MCE becomes an issue challenged in the courts here, remains to be seen.

VII. Should MCE Be Permitted or Required? (Pros and Cons)

The main focus of this paper is the arguments for and against MCE.

A. Arguments for MCE

1. Prevents Professional Obsolescence

The most frequently used and obvious claim is that MCE prevents professional obsolescence. That is, MCE will result in better informed and better skilled practitioners with increased awareness of new developments. "Since new knowledge is continually being developed, it is argued that a person's education should never end." (Rockhill, 1983, p.111) Lowenthal (1981) states that "It will help protect the public from professionals who are too lazy, uninterested, or egotistical to participate in continuing education. Participation in continuing education does not guarantee competence but not having to do it guarantees even less." (p.524)

Frye (1990) concluded:

> Despite legislators' confusion in clarifying the relationship between MCE and competency the practical impact of continuing education in keeping doctors and lawyers abreast of new developments is undisputed.

2. Voluntary Participation in CE is Inadequate

The claim that most practitioners voluntarily participate in CE may be unfounded. Lowenthal (1981) observed that only a minority of professionals may be participating in formal continuing education.

Phillips (1987) was more positive indicating that an estimate of 25 - 30 per cent of each profession do little more than the minimum to remain in practice.

McCarberg (1981) claims:

> There is no evidence that, without continuing education requirements, those who are in need of advanced learning will voluntarily engage in it. Insufficient dedication hampers an effective voluntary system of continuing education for all practitioners. It is felt that exposure to the information is better than no knowledge updating at all.

3. Difficulties in Implementation, While Real, Can Be Overcome

The following has been said in an American context with respect to this aspect of the issue:

> Experience tells us that any mechanism can be developed if the legal power to do so is legislated. Surely, a nation that can put a man on the moon, has the available technology to implement a MCE program. (Novello, 1977, p.26)

4. MCE will not Deter Dedicated Professionals from Exceeding Legal Requirements

Louis Phillips (1983), a prominent proponent of MCE in the U.S., observed:

> Arguments that professionals are only interested in obtaining the minimum number of credits for re-licensure overlook the integrity of professionals and their willingness to choose the most beneficial learning activities for their individual needs. (p.214)

5. Quality of Programs Will Be Available

Quality and quantity of CE programs will be maintained and perhaps improved. Shannon and Kenny (1986) studied the availability of pharmacy continuing education programs in 1985. At that date there were MCE requirements in more than 70 per cent of the states. They concluded that pharmacy CE program providers offered a real variety of programs in every region of the country. The number of programs available was more than enough for every pharmacist to meet MCE requirements without undue strain.

Frye (1990), in discussing continuing medical and legal continuing education observed:

> Since its inception compulsory education has been criticized for its potentially negative impact on the quality of educational programs. . . While these are reasonable concerns, few objective data are available to support them. (p.20)

Jahns (1986) investigated MCE of nurses in Florida. He concluded that MCE has enhanced rather than hindered the provision of opportunities for nurses' professional growth and development. It has created broader opportunities from which individuals can choose and it has encouraged employers and other interested parties to engage in the provision of continuing education.

6. Cost to the Professional and to the Consumer May Not Be That Substantial

With regard to cost, it is argued that once the quantity of programs increase (due to the existence of MCE), price will decrease, and since quality may also increase, the professional may be getting more for less money. Increased quality of care "could lead to decreased law suits and possibly decreased insurance costs"

for the professional or the institution that employs him or her. (Rizzuto, 1982, p.42)

With respect to the costs of MCE being passed on to the consumer, the following was stated regarding nurses:

> If the quality of nursing care improves it could be postulated that the patient's length of hospital stay might decrease, which might decrease his hospital costs. In addition, the patient could return to work sooner thus decreasing amount of salary lost due to sickness. (Rizzuto, 1982, p.41)

7. MCE Could Increase Public Confidence in Professionals

A legislated MCE requirement, which the public is aware of, could increase confidence in the professionals from whom they seek services. Present feelings of apprehension and anxiety about seeking a professional service could fade.

Lee and Sorensen (1988) supported this point of view in a study of users of accountants' services in Colorado. Seventy-seven per cent of the respondents agreed that MCE is in the best interest of clients.

8. The Existence of Strong Support for MCE

While there are strong views opposing MCE there are equally strong views supporting a MCE scheme. Louis Phillips (1986) has made the following statements:

> After two decades there is increasing evidence that a number of benefits are being obtained and that well-designed CE programs and improved standards can improve the results even further. (p.3)
>
> The high level of participation in CE by professionals on a voluntary basis appears to be an endorsement of the

> concept that there are benefits that will enhance performance even beyond the occasional travel to resort areas and tax advantages. (p.7)
>
> Yet even when one sorts through the rhetoric about providers making vast sums of money from programs and all the abuses of the system, there is still a general feeling that programs overall are improving and many excellent programs are being provided. (p.11)
>
> There is evidence that MCE is producing a number of changes that affect the professions, and the evolution of CE is providing proven approaches to obtaining desired outcomes. After two decades of experimentation, MCE may well take on new meaning and significance. (p.15)

The views of Mattran and Rockhill are significant.

> A profession and the public it serves have the right and, indeed the duty to impose standards on practitioners, as long as the standards are not arbitrarily and capriciously ordained. (Mattran, 1981, p.47)
>
> Until a better alternative is developed, mandatory education seems the only option. (Rockhill, 1981, p.60)

There is evidence of a changing attitude among professional nurses toward MCE. Weiss-Farnan and Willie (1988) compared the literature on MCE in nursing in 1973 with that in 1983. While there were numerous arguments against MCE in 1973 there were no articles published in 1983 challenging MCE. In fact, there was considerable evidence of growing support for the concept.

Two recent studies indicate some strong positive reaction toward MCE from professionals themselves. Frye (1990) noted that, while there is a small body of research showing significant practitioner opposition to MCE, these negative results are outweighed by the several studies showing a widely held attitude of approval and satisfaction with MCE among practising physicians and attorneys. She concluded that while many legal and medical bodies are opposed to MCE, most practitioners are not. Plewa et al (1990), in a survey of certified public accountants following the 1988

requirements of the American Institute of Certified Public Accountants for MCE for all its members, found a positive response to the requirement.

B. Arguments Against MCE

1. Learning Cannot Be Forced

As was mentioned earlier, there is inconclusive research evidence that participation in MCE (or CE) results in greater competency. This may be due to the claim that learning cannot be forced. Learning only takes place when there is a genuine desire and a readiness to learn. (Luzinski, 1975, p.36)

2. Application of Knowledge Cannot Be Forced

Even if learning could be forced by requiring the professional to pass an exam at the end of the session, this still does not mean that the professional can be forced to actually apply that knowledge in his or her practice. Jerry Apps (1980) has claimed that, "there are very few malpractice suits for lack of knowledge; it's the application of knowledge that people are concerned about." (p.10)

3. Voluntary Participants Resent MCE

Many professionals participate in CE voluntarily. Being forced to do something that one is already doing can lead to resentment and a lack of desire to learn. Resentment is caused by being forced to participate, and is magnified because a record of this participation must be kept.

4. Required Courses Are Not Always Relevant to Job

A further complaint is that practitioners may be forced to take courses or participate in programs that are of no relevance to their particular practice. They resent learning basic knowledge (with which they are already familiar), and even more so if they are engaged in a specialization.

5. Completion of MCE Requirements Does Not Guarantee Competence

It may be hard to dispute the claim "that CE cannot teach wisdom and dedication. It may be counterproductive by causing professionals to have false confidence in their competence." (Lowenthal, 1981, p.524) In addition, it is felt that education cannot solve the accountability problem and may actually add to it by misleading the public into thinking that the professional is qualified when he or she may not be. (Rockhill, 1983)

6. Cost to the Professional

The cost to the professional is made up of the cost of the activity and the cost in time, hence loss of income, to the practitioner. Food, transportation, and lodging are part of the expense as are child care expenses. Indirect costs include the cost in increased time that is needed for colleagues to perform the work for those participating in CE, and less time or money for family needs, or less time and energy to work an extra shift or take a day off. (Dowling, 1985)

7. Cost to the Consumer

Since CE (either voluntary or mandated) will produce costs to the professional and/or the employers of professionals, the costs will likely be passed on to the consumer. The public may also be inconvenienced in terms of decreased availability of services.

(Cooper, 1980) That is, less services will be available, because of the time the practitioner must spend in CE programs, and hence away from his or her practice or job.

8. Administration Problems for the Professional Associations

If the professional associations are given the task of administering MCE, they will undoubtedly experience costly and difficult situations. They may not have adequate resources to handle this responsibility. "Additional financial and human resources are needed along with new rules and regulations to deal with complex matters for which there is little or no precedent on which to base decisions." (Phillips, 1983, p.211) Even if adequate resources were available for the initial implementation of an MCE scheme, there is the additional cost of accrediting and approving programs. Policing and record keeping costs are also a factor. Finally, there is the problem of availability of CE programs. Such programs are generally more available and less costly to urban practitioners rather than rural ones. Professional associations, both large and small, have logistical problems. The situation can best be described as follows:

> Smaller memberships suffer from a lack of finances to present quality programs. Larger memberships, which may be able to generate the financial resources through fees, face high administrative costs in planning courses and recording participation. (Colvin, 1979, p.9)

9. Negative Implications for Employers of Professionals

If employers were required to be involved in the administration of an MCE scheme, in particular paying for the MCE expenses of their employees, their labour costs will increase and these will be passed on to the public.

If, on the other hand, professional employees were required to pay both the direct and indirect costs of MCE, their enthusiasm for such activities would be decreased substantially and they would seek redress at the bargaining table.

10. Problems With Reciprocity of CE Credits Between Provinces

Portability of professional credentials from province to province is already a problem. MCE requirements, which may vary from province to province, make this issue even more complex than it currently is.

11. Quality of Programs May Decrease

Even if administrative difficulties were overcome and CE programs were increased, there arises the concern that this increase may result in a decrease in their quality. This increase may come about due to the efforts of educational entrepreneurs who see an opportunity to make money. This turn of events has happened in the U.S. where the market has been flooded with programs and groups rushing to meet the demand and to set up a profitable business. As well, the standards of those providing MCE may be decreased due to the immediate requirement for more programs. (Rizzuto, 1982)

12. The Existence of Strong Opposition to MCE

Besides these claims and arguments, there is strong opposition to MCE from some professionals and those with similar interests as the professionals. Their basic complaint is that there is too much regulation in our lives. It is felt that

> Unless requirements can be demonstrated as essential to performance, the requirement itself becomes a barrier and limits equal access to jobs, advancement, and the right to work at one's profession. (Rockhill, 1981, p.64)

Voluntary adult learning is perceived by some as a basic human right which must be protected. "Adults should not be coerced to participate in educational programs; the right not to participate must be preserved." (Rockhill, 1983, p.115). Stuart (1975) claimed that a legislative mandate for CE will relinquish internal professional control in favour of external societal control. Or, as Cooper (1975, p.475) said, "establishing legal requirements downgrades professional autonomy and the right of the individual to decide which learning approaches are best suited to meeting his needs."

VIII. Mechanisms for Implementation: Statute, Regulation, or By-Law

A MCE scheme can be instituted by a statute or by regulations or by-laws pursuant to an enabling provision in a statute. Action through statute gives the government very substantial control and, by implication, very substantial responsibility. In Alberta this avenue has not been chosen. Where MCE exists or there is potential for it to exist, there is enabling legislation under which regulations regarding MCE can be passed. This process, under normal circumstances, leaves much control and responsibility with the profession since, according to the Principles and Policies Governing Professional Legislation in Alberta (1990), regulations must be approved by the profession's governing body and, where appropriate, by a majority of the membership in the profession (p. 1). It must be noted that the policy does provide authority for the Lieutenant Governor in Council to amend, reject, or enact regulations in consultation with the profession as well as to approve regulations (p.6).

In Alberta the by-law scheme is not operational with respect to future legislation because the above noted policy limits by-laws to administrative matters which do not have a public impact.

IX. Penalties for not Meeting MCE Standards

In order for an MCE scheme to be effective in accomplishing its goal of increasing professional competence, there must be adequate penalties (to act as a deterrent) imposed on those not meeting the prescribed MCE standards.

Among the penalties that are used are the following which are listed in order of severity:

1) a fine
2) probationary registration or certification
3) registration or certification limited to certain functions
4) decertification or denying renewal of certification.

All of the penalties involve significant policing and enforcement problems.

Alberta's policy governing professional legislation has an important provision with respect to penalties. It states that disciplinary or registration decisions relating to MCE shall be appealable (p. 3).

X. Financial Implications of MCE

A major issue of debate regarding MCE is who should have to pay for this type of program. The costs that have to be met include the course fees, loss of productive time, monitoring costs, and implementation costs. Because of the significant costs involved, there is reluctance by all parties involved to incur them. The parties include the public, the professionals, the professional association, employers, and the government. There are those that feel all these groups should come to some sort of an agreement on how much each will contribute to an MCE scheme, because all

involved benefit in some way. (Lowenthal, 1981) However, all involved do not agree that they should share the cost.

In the final analysis, much of the cost will be borne by consumers as a consequence of self-employed professionals or employers passing on the cost through increased fees or increased cost of goods and services. Furthermore, since the provincial government, municipal governments, school boards, and hospital boards employ many professionals, employer cost of MCE in these cases will be passed on to the taxpayers. The cost of MCE by professional employees not picked up by employers will have to be borne by individual professionals. It would be naive to believe that such costs would not regularly appear as a bargaining item at the negotiating table.

It should be noted that the costs of voluntary CE by self-employed professionals and employers will also be passed on to consumers. However, the pressure on employers to assume costs for voluntary CE programs of their employees is not as great.

The Alberta Government has declared it has no intention of directly contributing to the MCE costs of professionals. Its policy governing professional legislation indicates each profession shall develop continuing education programs with its own resources (p. 3).

XI. What Should Government Involvement Be

The government is required to provide the requisite legislation for MCE. Whether there should be other government involvement is an issue. As there was for other issues, there are arguments for and against other government involvement.

A. Arguments for Government Involvement

There are a number of arguments for government involvement in any MCE scheme. Lowenthal (1981), for example, states that

> Public interest groups indicate that the professionals already have enough control, and the public now needs to have more influence over the quality of professional services it receives. (p.524)

Another claim along the same lines is as follows:

> Most people tend to suspect a professional organization's power over which they believe they have little or no control. The public also suspects professionals of looking out for their peers and using mandated continuing education as a smoke screen for incompetent members' behaviour. (Apps, 1980, p.7)

B. Arguments Against Government Involvement

An argument against government involvement is the claim that the professions would be relinquishing control of their education to outside sources that would specify educational content, requirements, and rules. (Lowenthal, 1981) Such action reduces professional autonomy which is highly valued by the professions. As Mattran (1981) has stated, it is not the fact of a mandate that is so repulsive so much as the source from whence it comes. It would be more acceptable if the professional associations imposed the MCE requirements rather than an outside body that has no direct ties to the profession. Mattran (1981) also feels that government intervention is only justified

> ... if the state, in response to the desire of a professional body to improve through continuing education the services offered to the public, uses its power of licensure to ordain into law standards and procedures recommended by the professional body. (p.47)

Selden feels even more strongly on the issue

> Consistent with this traditional concept of a profession is the principle that each profession should have sole responsibility for disciplining and expelling its incompetent members. Therefore, if continuing education is offered, the profession should be the final judge of the content of the offerings; and if continuing education should be mandatory, the profession should be empowered to exercise the mandate. (Selden, 1976, p.63)

C. What Degree of Government Involvement

Beyond the recognition that the government is required to provide the requisite legislation for MCE, there is no agreement on what specific role, if any, it should have in the MCE scheme.

XII. ALTERNATIVES TO MCE

Because of the philosophical, administrative and financial problems associated with implementing a MCE requirement, a combination of alternatives might be considered. Among the alternatives are the following:

1. Encouragement by professional associations and employers for individuals to engage in continuing education programs. The encouragement could be in the form of providing programs or, in the case of employers, providing time off or financial and other incentives.

2. Professional associations could engage in practice reviews of its members on a sampling or periodic basis and/or on the basis of complaints received.

3. Employers can engage in evaluations of their employees. Part of the evaluation process could include identifying potential

areas of weakness and continuing education programs which might be taken.

4. Those responsible for re-registration might develop examinations which would have to be passed before an individual was re-registered.

5. Individuals applying to be registered might be required to provide proof that they have a given number of hours of practice since last being registered. Those not meeting the requirement might be required to pass an examination or engage in a continuing education program.

XIII. CONCLUSION

MCE is a scheme which many feel is needed in order to reduce professional incompetence. At the same time, however, while many others agree that professional incompetence needs to be dealt with, they feel that MCE is not the way to do it. This Discussion Paper has summarized the arguments of these two groups, and examined several other aspects of the MCE issue. There are no clear cut answers to any aspects of this issue. There are many moral and philosophical arguments made, and there are varied and strong opinions either in favour or against MCE. Arguments based on research are inconclusive.

Thus, those that support MCE and feel it is needed in present day society should advocate carefully designed MCE schemes to keep to a minimum the potential negative features. For those strongly opposed, but who still feel professional incompetence is a problem, alternatives will have to be sought.

Professionals and their associations have a demanding task. Consumers demand competence. Professional associations and their

members must take steps to satisfy this demand. Failure to do so is to invite government intervention.

Employers of professionals are in a unique circumstance. In addition to responding to the MCE or CE needs of the professional employee, they may set MCE requirements as a condition of employment. In either scenario they are faced with addressing, in whole or in part, the cost of the program which will be reflected in increased cost of goods and services.

Governments faced with a complex and controversial issue have a demanding task as they attempt to balance the rights and responsibilities of the consumer with the rights and responsibilities of professionals.

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APPENDIX I

SECTION 20 of the Bill re Health Professions Introduced in Ontario Legislature in June 1990

20.01

The Council shall develop and establish by regulation a continuing competence program to be administered by the Continuing Competence Committee for the purpose of maintaining and enhancing the competence and standards of practice of members in the care of patients and in record keeping in relation to members' practices.

20.02

In establishing the continuing competence program referred to in section 20.01, the Council may select from one or more of the following approaches:

(a) administering written or oral tests of clinical knowledge, skill and judgement.

(b) assessing the member's performance in actual practice settings, simulations or both,

(c) assessing the member's ability to maintain records in relation to his or her practice

(d) requiring members to participate in continuing education and remediation programs

(e) such other methods of assessing and maintaining competence as the Council deems to be appropriate.

20.03

The Council or Continuing Competence Committee may appoint members of the College or other persons to assist them in the development, establishment, or administration of the program and may designate such persons as assessors for the purposes of such programs as may be developed and approved to assess the competence of individual members.

20.04

Every member whose standards of practice are the subject of an assessment as part of the continuing competence program shall co-operate fully with the Continuing Competence Committee and with its assessors, and for the purposes of this section the cooperation required of a member includes,

(a) permitting assessors appointed by the Continuing Competence Committee to enter and inspect the premises where the member engages in the practice of the profession;

(b) permitting assessors appointed by the Continuing Competence Committee to inspect the member's records of the care of patients;

(c) providing to the Continuing Competence Committee or its assessors information requested by the Committee or the assessors, as the case may be, in respect of the care of patients by the member or the member's records of the care of patients;

(d) providing the information mentioned in clause (c) in the form requested by the Continuing Competence Committee or its assessors;

(e) conferring with the Continuing Competence Committee or its assessors when requested to do so by the Committee or its assessors;

(f) providing to the Continuing Competence Committee such evidence as the Committee may require in respect of the member's participation in a program of continuing education that is provided in relation to the maintenance of the member's standard of competence; and

(g) where so directed by the Continuing Competence Committee, attending at and participating in a program designed to evaluate the knowledge, skill and judgment of the member.

20.04A

Notwithstanding any provision in any Act or regulation providing for the confidentiality or secrecy of health records, paragraphs (a) and (b) of section 20.04 apply, with necessary changes, to every regulated health care institution, employment agency and registry, and to every person, other than a patient that employs a member of a health profession, associates in partnership or otherwise with a member of a health profession for the purpose of offering health services, or procures employment for a member of a health profession.

20.05

Information given by or about the member pursuant to sections 20.04 and 20.04A in the course of a continuing competence program shall not be used against the member in any proceeding before the Discipline or Fitness to Practise Committees, except for knowingly giving false information.

20.06

Notwithstanding section 20.05, the Continuing Competence Committee may,

(a) refer the member to the Executive Committee in respect of the giving of false information or failure to cooperate for the purposes of a determination of whether a referral to the Discipline Committee on the grounds of professional misconduct is warranted;

(b) refer the member to the Executive Committee to determine whether a board of inquiry should be appointed for the purpose of determining whether the member should be referred to the Fitness to Practise Committee in respect of incapacity, or whether a new investigation should be commenced for the purposes of determining whether the member should be referred to the Discipline Committee in respect of professional misconduct or incompetence.

20.07

For the purposes of a referral under section 20.06(b) the Continuing Competence Committee shall identify the member, and allege a specific deficiency, but no further information shall be provided, and where such a referral has been made, the Executive Committee may direct the Registrar to commence an investigation pursuant to the powers contained in section 19.

APPENDIX II

SOME U.S. COURT DECISIONS

(1) In Dent v. West Virginia, 129 U.S. 114, 9 S.C.T. 231.32 L. Ed. 623 (1889) the argument of denial of "due process of the law" was rejected, and the constitutionality of an MCE requirement for physicians was upheld. This case was then subsequently followed by other U.S. courts.

(2) The California Supreme Court in the case of Gamble v. the Board of Osteopathic Examiners, 130 P. 2d 382, 21 C2d 215 (1942), rejected the argument that a 1941 law was discriminatory because it required continuing education for osteopaths but not for physicians." (Edward and Green, 1983, p.44)

(3) In the case of State ex. rel. Week v. the State Board of Examiners in Chiropractic, 30 N.W. 2d 187, 252 Wis. 32 (1947), the Wisconsin Supreme Court stated,

> The fact that a person is once licensed does not create a vested property right in the licenses, as advancements in trade or profession may require additional conditions to be complied with if the general welfare of the public is to be protected. (Edwards and Green, 1983, p.44)

(4) An MCE requirement for pharmacists was also upheld in Lipman v. Ohio State Board of Pharmacy (unreported).

(5) "In Week v. State Board of Examiners (unreported) the Wisconsin court spoke of reasonable qualifications to be met to practise a trade or profession." (Edwards and Green, 1983, p.44)

(6) In State v. Boran, 76 P. 2d 757, 51 Ariz. 818, 115 A.L.R. 254 and Butcher v. Maybury, Wash. D.C., 8F. 2d 155 it was stated that the test for the reasonableness of a requirement is that the requirement must be necessary for the protection of the public health or must bear some relationship to the service to be rendered by the practitioner. (Edwards and Green, 1983, p.44)

(7) This issue of reasonableness was dealt with in Snedeker v. Wernman Limited, 151 So. 2d 439 (1963) where the court held that the education requirement was unconstitutional. The court was convinced that sufficient evidence existed to rule "that the education required was 'obviously unrelated to competent performance' and therefore not a reasonable requirement in the exercise of the police power of the state." (Edwards and Green, 1983, p.44)

(8) In Baronan v. State Bd. of Nursing Home Administrators, 239 S.E. 2d 533, 143 Ga. App. 605 (1977) it was held that it was constitutional to require a nursing home administrator to participate in CE in order to renew his license, but where it was also stated that the right to practice any profession or occupation is necessarily a valuable right and is entitled to constitutional protection. The court felt the requirement was reasonable, and determined this by looking at the impact upon the student and the public.

Lastly, (9) In Harrah Independent School District v. Martin, the U.S. Supreme Court upheld the punishment for not meeting CE requirements as being constitutional, but whether making CE mandatory was constitutional was not an issue, and hence was not dealt with by the Court.